MEDICAID MANAGEMENT INFORMATION SYSTEM

Bismarck, North Dakota

INFORMATION SYSTEM AUDIT

For the period October 1, 2001 through September 30, 2002

Client Code 2300

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TRANSMITTAL LETTER

March 6, 2003

Honorable John H. Hoeven, Governor
Members of the North Dakota Legislative Assembly
Carol K. Olson, Executive Director, Department of Human Services

Transmitted herewith is the information system audit of the Medicaid Management Information System (MMIS) for the period October 1, 2001 to September 30, 2002. This audit resulted from the statutory responsibility of the State Auditor under NDCC § 54-10-01.

MMIS is used to process and pay eligible providers for claims primarily for the Medicaid program, but also includes claims for other programs and agencies.

MMIS was selected for this audit because it is considered a high-risk information system for the State of North Dakota, according to the Application Risk Assessment Report of all state computer systems, issued by the State Auditor's Office May 15, 2002. Risk was evaluated based on several factors, including, but not limited to, size and complexity of the system, sensitivity of the data, and regulatory requirements. "High-risk" does not necessarily indicate problems with the system, but indicates a higher potential for significant problems to occur.

Inquiries or comments relating to this audit may be directed to Donald LaFleur, Information Systems Audit Manager, by calling (701) 328-4744. We wish to express our appreciation to the Department of Human Services for the courtesy, cooperation, and assistance provided to us during this audit.

Respectfully submitted,

Robert R. Peterson
State Auditor

EXECUTIVE SUMMARY

The purpose of this report is to provide our analysis, findings, and recommendations regarding our audit of the Medicaid Management Information System (MMIS). This audit was primarily an information system audit; however, we also addressed operational issues related to MMIS and its operation within the Department of Human Services.

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Our audit resulted in the following significant findings:

- Inadequate controls surrounding duplicate payments
- Inefficiencies in the automatic denial of claims
- Errors in the review of suspended claims

BACKGROUND INFORMATION

System Overview

The Medicaid Management Information System (MMIS) adjudicates over 200,000 claims per month for the Medicaid program and the following other programs and agencies: Aging Services; Developmental Disabilities; Children Special Health Services; Vocational Rehabilitation; Disability Determination; State Hospital; Department of Public Instruction; Department of Corrections; and Youth Correctional Center.

MMIS was put into service in 1978 by EDS, and has been maintained from that time by the Information Technology Department (ITD). ITD and other vendors have made numerous enhancements and modifications to MMIS since its inception. For example, in 1995, a vendor from Utah developed and incorporated the Pharmacy Point of Sale System and, in April 2002, developed and incorporated NCPDP Version 5.1 into the pharmacy point of sale system, making that portion compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Program Overview

The Medicaid and Children's Health Insurance Programs were established under Titles XIX and XXI, respectively, of the Social Security Act. The North Dakota State Legislature authorized these programs by enacting legislation, which is contained in North Dakota Century Code Title 50.

The Medicaid Program was established to provide medical and other health-related services to the aged, blind, or disabled persons; dependent children; and people otherwise eligible who do not have sufficient income and resources to meet their medical needs.

Medicaid eligibility determination is handled in two systems; they are the Vision system and Technical Eligibility Computer System. For the month of April 2002, there were 47,020 Medicaid Recipients, of which 37,148 received a medical service.

Claims Submission

Providers submit claims through the following methods:

- Point of Sale System — this is an on-line system used by pharmacies to submit drug claims electronically using a real time process.
- Paper claims — providers submit claims on standardized paper forms applicable to the type of claim. These documents are either keyed manually or are scanned and verified by the data entry unit.
- Datatrac/Medtrac — this is a system maintained by BlueCross BlueShield (BCBS). Providers submit Medicaid claims through this system and BC/BS sends them electronically to Medical Services to be processed.
- Proprietary Software — this is an electronic process developed by the department that providers may use to submit claims electronically directly to the department.

- Third Party Payer files — other payers, such as Medicare, send claims that they are primarily responsible for and Medicaid is secondarily responsible for directly to the department using electronic media such as tapes and cartridges.

Claims Adjudication

Once claims are submitted into MMIS, they are given an Internal Control Number (ICN). The ICN is a unique number used to specifically identify each claim. The claims are then run through the adjudication process.

Through this process, the claims are subjected to edit checks, including duplicate payment checks, provider and recipient eligibility checks, coverage checks and various other edit checks that are specific to provider types and specialties. The claim is priced based on the information submitted on the claim.

“Clean” claims are adjudicated by the system, while claims that are “not clean” are suspended for the reviewers to “work” before they are adjudicated.

Adjudicated claims can be fully paid, partially paid, or denied. Once adjudicated, they are reported on the remittance advice, included with the payment to the provider, and put into claims payment history.

Goals of the system:

- Adjudicate 90% or more of clean claims within 30 days.
- Process claims accurately and efficiently.
- Account for all funding sources used to pay claims.
- Generate data used to complete reports for state and federal reporting guidelines.

MMIS Paid Claims

The following table shows paid claims from MMIS for state fiscal years 2001 and 2002.

PAID CLAIMS BY STATE FISCAL YEAR		
	2001	**2002**
Medicaid		
Title XIX	286,294,570	313,796,494
Intermediate Care Facility for the Mentally Retarded; Elderly and Disabled Waiver	54,192,916	54,178,805
Developmental Disability Waiver; Traumatic Brain Injured Waiver	45,598,312	48,163,940
Human Service Centers	15,367,252	15,480,602
Indian Health	7,461,993	8,009,421
Children's Health Insurance Program; Women's Way	2,947,976	4,478,293
Family Planning	929,949	1,095,304
Title XIX Refugee Assistance	-	34,495
Subtotal	412,792,968	445,237,354
Non-Medicaid		
Service Payments for the Elderly and Disabled	7,352,658	8,088,157
Basic Care	3,884,818	2,881,379
Developmental Disability	3,106,640	2,850,540
Department of Corrections	1,165,833	778,123
Disability Determination Services	453,998	471,432
Non-Title XIX Refugee Asst	383,047	202,766
Children's Special Health Services	346,090	181,926
Vocational Rehabilitation	282,585	305,115
Other	6,260	6,114
Subtotal	16,981,929	15,765,552
Total	**429,774,897**	**461,002,906**

OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of this audit of the Medicaid Management Information System (MMIS) for the period October 1, 2001 to September 30, 2002 was to answer the following questions:

1. Are security controls for DHS adequate?
2. Are controls preventing duplicate payments adequate?
3. Is the financial report used to report MMIS expenditures accurate?
4. Is the department giving adequate priority to a replacement system for MMIS?
5. Are claims with a third party liability accurately processed?
6. Does MMIS adequately process suspended claims?
7. Are suspended claims properly adjudicated?

This audit was conducted in accordance with *Standards for Information Systems Auditing* issued by the Information Systems Audit and Control Association and *Government Auditing Standards*, issued by the Comptroller General of the United States.

ARE SECURITY CONTROLS FOR DHS ADEQUATE?

Summary of Audit Work Performed

Security controls are necessary to safeguard information against unauthorized use, disclosure, modification, damage, or loss. Proper security controls ensure that access to systems, data, and programs is restricted to authorized users.

In our review of security controls at the Department of Human Services, we noted that the Health Insurance Portability and Accountability Act (HIPAA) required changing security controls within the department. HIPAA requires that all entities involved with health care must have documented, established security procedures to protect the confidentiality, integrity, and availability of individually identifiable health information.

In May, 2002, DHS used the HIPAA EarlyView™ security self-assessment tool (Tool) developed by the North Caroline Healthcare Information and Communications Alliance (NCHICA), Inc. to conduct a review of its security policies, procedures and practices. The Tool contains 521 questions contained in 24 sub-categories within five major categories of the HIPAA Security Rule. Those major categories are administrative procedures, physical safeguards, technical security services, technical security mechanisms and electronic signatures. The department used the questions in the Tool to study the differences between security in place and what is required to be compliant with the HIPAA Security Rule. The department found itself to be 29% in compliance with the proposed HIPAA Security Rule.

We reviewed the department's analysis and noted the following major findings:

- The department needs to develop formal documented policies that ensure uniform security procedures.
- Security is not always assigned on a "need to know" basis.

Because the client had performed its own analysis and noted these findings, we did not test security rights at the department. We did note that the department had a corrective action plan to comply with the HIPAA Security Rule.

Auditor's Opinion

In our opinion, the department had weaknesses in its security during our audit period, but has identified its security weaknesses and developed a plan to correct those weaknesses noted.

ARE CONTROLS PREVENTING DUPLICATE PAYMENTS ADEQUATE?

Summary of Audit Work Performed

MMIS has controls to identify claims as exact duplicates or suspected duplicates and suspends those claims to be processed by reviewers. This is to ensure providers are only paid once for services provided.

We identified potential duplicate claims by looking for duplicate values in selected fields for paid claims from two groups: professional services containing dental, medical and crossover claims, and institutional services containing inpatient, nursing home, and outpatient claims. We then tested a sample of these potential duplicate claims to determine if duplicate payments were being properly detected. We also reviewed program coding to identify how the system detected duplicate payments.

Audit Findings

Inadequate controls surrounding duplicate payments

In the area of professional services, we identified 19,787 claims that had potential duplicates. Since some of these claims had more than one potential duplicate, there were a total of 23,870 potential duplicates for $1,326,768. We selected 50 claims to review, which consisted of 66 potential duplicates for $3,041. We identified eight duplicate claims for $378. Prior to our testing, adjustments had been made and the money recovered for six of these claims totaling $358.

In the area of institutional services, we identified 272 claims that had 285 potential duplicates for $140,430. We selected 30 claims to review, which comprised 32 potential duplicates for $12,181. We identified ten duplicate claims for $9,636. Prior to our testing, adjustments had been made and the money recovered for all ten duplicate claims.

We noted the following reasons duplicate payments had occurred:

- Claims that had been suspended as exact or suspect duplicates, but were improperly approved for payment by reviewers.
- Timing differences in the payment of claims and the posting to appropriate files caused duplicate payments to not be detected.
- Crossover claims (claims which are passed to MMIS by Medicare) are given a generic procedure code by MMIS, making it difficult to detect duplicate payments.

Recommendation:

We recommend the Department of Human Services implement additional edit checks to ensure that duplicate claims are detected and suspended.

Agency Response:

The MMIS system is almost 25 years old and as such, lacks certain edit checks that would aid in preventing the possibility of duplicate payments. The program changes necessary to alleviate duplicate payments would be very costly and time consuming. The Department has received authorization from the Legislature to begin the process of developing a new MMIS. We plan to incorporate the required controls when a new system is implemented.

While most duplicates noted in this audit were detected and corrected prior to the audit, the Department does agree that additional action is necessary to reduce the number of duplicate claims paid through MMIS. We will provide additional training to reviewers to ensure they better understand how to adjudicate claims that have been suspended as a potential duplicate payment. Also as of April 2003, the Department has changed the way it processes Medicare crossover claims. Providers will be required to submit Medicare claims using standard claim forms and standard data elements. As a result payments for Medicare crossover claims will be subject to the same edits as other claims processed through MMIS.

Auditor's Opinion

In our opinion, the controls are not adequate within the system and its surrounding processes to prevent duplicate payments.

IS THE FINANCIAL REPORT USED TO REPORT MMIS EXPENDITURES ACCURATE?

Summary of Audit Work Performed

The client creates a Quarterly Medicaid Statement of Expenditures from the SB1-890-GG report created from MMIS. This report summarizes expenditures by match code. Each program processed by MMIS has its own match code.

In order to verify that the amounts contained in the SB1-890-GG report were correct, we reviewed the program coding used to create the report and used the data file to recreate and verify the amounts for the March, 2002 report.

Auditor's Opinion

In our opinion, the financial report used to report MMIS expenditures is being accurately prepared.

IS THE DEPARTMENT GIVING ADEQUATE PRIORITY TO A REPLACEMENT SYSTEM FOR MMIS?

Summary of Audit Work Performed

MMIS was put into service in 1978 by EDS and has been maintained by ITD since that time. The system was originally designed to process Medicaid claims. There have been numerous enhancements and modifications to the system in the time since then, allowing the system to process medical claims for various other programs and state agencies.

Because of the age and complexity of the system, programming changes to the system are both difficult and expensive. For the fiscal year July 1, 2001 to June 30, 2002, the department had $1,494,136 of maintenance costs for MMIS.

In addition to the age and limitations of MMIS, the federal government currently provides 90% of the funding for a new system, with only 10% of the cost being funded by the state.

We reviewed the department's IT plan and noted that an MMIS rewrite is included in the department's IT plan. We also reviewed the agency budget request and the executive budget recommendation and noted funding for a replacement system was included in each of these.

Auditor's Opinion

In our opinion, the department is adequately giving priority to a replacement system for MMIS.

ARE CLAIMS WITH A THIRD PARTY LIABILITY ACCURATELY PROCESSED?

Summary of Audit Work Performed

MMIS operates on a cost-avoidance basis, meaning that the system will not pay claims until a third-party payer has paid their portion, when applicable. This is done by identifying insurance coverage for recipients and comparing the type of claim to the type of insurance coverage.

We reviewed program coding to determine that the system was properly processing claims for third party liability in accordance with the criteria in the department's MMIS manuals. We also tested a sample of paid claims for recipients with third party liability insurance to ensure that the system had properly accounted for third party liability before payment.

Auditor's Opinion

In our opinion, MMIS is properly processing and accounting for third party liability.

DOES MMIS ADEQUATELY PROCESS SUSPENDED CLAIMS?

Summary of Audit Work Performed

MMIS has edit checks to determine if information contained on claims is valid. Claims which do not meet these edit checks are suspended for reviewers to determine if the claim should be paid, changed, or denied. A claim can suspend with multiple error codes.

During our review of the system, we noted that there were a large number of suspended claims for reviewers to "work". As of July 15, 2002, we noted that there were 45,330 claims in the suspended claims file. Some of these claims had been submitted as much as six months before, but had not yet been reviewed because of a backlog.

In order to determine if the system could cut down on this backlog, we reviewed error codes with the department's reviewers. Together we identified 56 error codes that could be automatically denied by MMIS for claims submitted electronically.

Audit Findings

Inefficiencies in the automatic denial of claims

From the suspended claims file of September 16, 2002, we noted 4,283 electronic claims with a total of 6,438 errors that had been suspended and not yet reviewed. Of the 6,438 errors for the electronic claims in suspense 915 were one of the 56 error codes identified as being error codes that could be automatically denied. These 915 error codes occurred on 587 unique claims. By not automatically denying these claims, the department is increasing the workload for reviewers, adding to the backlog of suspended claims, and creating the potential that these claims may not be correctly denied by the reviewers.

Recommendation:

We recommend the Department of Human Services modify MMIS to automatically deny claims that do not need to be reviewed.

Agency Response:

We agree with the recommendation and will revise the edit program to automatically deny electronically submitted claims that contain errors that do not need to be resolved by claims reviewers . This should result in increased productivity of the claims reviewer staff.

Auditor's Opinion

In our opinion, MMIS is suspending too many claims for review.

ARE CLAIMS SUSPENDED FOR MANUAL REVIEW PROPERLY ADJUDICATED?

Summary of Audit Work Performed

MMIS contains edit checks and suspends claims that are “not clean” for reviewers to ”work”. The reviewers then determine whether the claim should be paid, denied, or changed.

We tested a sample of claims that had been suspended and reviewed to determine if the claims had been properly resolved.

Audit Findings

Errors in the review of suspended claims

We tested 76 suspended claims that had been adjudicated, and noted two claims that had been paid at incorrect amounts, and six claims that had been suspended as exact or suspect duplicates but were improperly approved by a reviewer for payment.

Recommendation:

We recommend the Department of Human Services ensure claims suspended for manual review are properly adjudicated.

Agency Response:

While the Department has a goal to process all claims accurately it is very difficult to achieve. Reviewers make hundreds of decisions each day concerning payment issues. It is inevitable that some mistakes will occur in the course of reviewing thousands of claims every year. While we believe it is impossible to guarantee 100 percent accuracy we do agree that additional training of reviewers is necessary to keep errors to a minimum. We will provide additional training through periodic staff meetings and individual assistance where necessary. In addition, the Department is participating in a Federal initiative designed to determine if the state is paying claims accurately. We will use this tool to further evaluate our claims payment accuracy and address any trends found during this claims payment review process.

Auditor’s Opinion

In our opinion, claims suspended for manual review are not being properly adjudicated in all cases.